# DA—Cred

## 1NC

### 1NC—Credibility DA (Top)

#### Patient-doctor trust is high

Giroux, 14 -- Bloomberg reporter [Greg, "Doctors Running for Congress Ditch Suits for White Coats," Bloomberg, 7-13-14, www.bloomberg.com/news/2014-07-14/doctors-running-for-congress-ditch-suits-for-white-coats.html, accessed 8-24-14]

On the 2014 campaign trail, white is the new olive drab. After the 2001 terrorist attacks on the U.S., political candidates with military ties showed up in their ads in uniform. This year, those with medical backgrounds are attacking Obamacare wearing their white coats. It’s no accident: polls show nurses and doctors are among the most trusted people in America. Politicians are among the least trusted. All three commercials for Monica Wehby, an Oregon Republican seeking to unseat Democratic Senator Jeff Merkley, have shown her in a hospital setting. “As a pediatric neurosurgeon, I know firsthand how devastating Obamacare is for Oregon families and patients,” Wehby said in one of her ads, which was interspersed with footage of the candidate in surgical scrubs. The “Grey’s Anatomy” backdrop comes as Republicans seek to gain control of the U.S. Senate and, with their House majority counterparts, pass a law repealing 2010’s Affordable Care Act. The quest is gaining urgency as Americans become more accepting of the law. Republicans need a net gain of six seats for a Senate majority. Fifty-three percent of Americans oppose the law, though just 32 percent say it should be repealed, according to a Bloomberg National Poll last month. Fifty-six percent say they want to keep Obamacare with “small modifications.” Wardrobe Messaging The latest wardrobe preferences for political ads also put distance between some candidates and the unpopular Congress they are seeking to join. About 82 percent of Americans say nurses have a “high or very high level” of honesty and ethical standards, the top spot among 22 professions rated in a December Gallup survey. Pharmacists were tied for second at 70 percent, and medical doctors were tied with military veterans for fourth at 69 percent. Medical professionals have high approval ratings because people view them as “primary care-givers,” said Frank Newport, Gallup’s editor-in-chief.

#### Increased medical autonomy decreases public trust—empirics prove.

O’Neill 1 (ONORA O’NEILL, philosopher and a crossbench member of the House of Lords, “AUTONOMY AND TRUST IN BIOETHICS”, 2001)//Miro

During these years no themes have become more central in large parts of bioethics, and especially in medical ethics, than the importance of respecting individual rights and individual autonomy. These are now the dominant ethical ideas in many discussions of topics ranging from genetic testing to geriatric medicine, from psychiatry to in vitro fertilisation, from beginning to end of life problems, from medical innovation to medical futility, from heroic medicine to hospices. In writing on these and many other topics, much time and effort has gone into articulating and advancing various conceptions of respect for persons, and hence for patients, that centre on ensuring that their rights and their autonomy are respected. Respect for autonomy and for rights are often closely identified with medical practice that seeks individuals’ informed consent to all medical treatment, medical research or disclosure of personal information, and so with major changes in the acceptable relationships between professionals and patients. Medical practice has moved away from paternalistic traditions, in which professionals were seen as the proper judges of patients’ best interests. Increased recognition and respect for patients’ rights and insistence on the ethical importance of securing their consent are now viewed as standard and obligatory ways of securing respect for patients’ autonomy. Rights and autonomy have played a lesser, yet still a significant, part in other areas of bioethics, including even environmental ethics. For example, rights may be invoked in arguing for prohibitions on marketing unlabelled food products containing additives or GM crops or on adding chemicals to water supplies, with the thought that rights are violated where individuals cannot refuse, nor therefore choose, because they are kept in ignorance or unable to opt out. Agricultural regulations have been condemned as violating or as failing to protect animal rights, or farmers’ rights to choose how to cultivate their land. Pollution controls have been attacked as violating the purported rights of individuals to conduct their lives and their businesses as they see fit. We might expect the increasing attention paid to individual rights and to autonomy to have increased public trust in the ways in which medicine, science and biotechnology are practised and regulated. Greater rights and autonomy give individuals greater control over the ways they live and increase their capacities to resist others’ demands and institutional pressures. Yet amid widespread and energetic efforts to respect persons and their autonomy and to improve regulatory structures, public trust in medicine, science and biotechnology has seemingly faltered. The loss of trust is a constant refrain in the claims of campaigning groups and in the press. In many developed countries, and particularly in the UK, there is evidence that mistrust of various professions, experts and of public authorities is quite widespread. This loss of trust is often ascribed to the supposed untrustworthiness of scientists and biotechnologists, even of doctors, and of those holders of public office who legislate for and regulate their activities. Medical professionals and regulators, politicians and civil servants, biotechnology companies and scientists, it is often suggested, pursue their own interests rather than those of patients or of the public. If true, these claims suggest that measures introduced (in part) to improve individual autonomy and to ensure that treatment and research do not proceed without informed consent have failed to secure trust, and may even have damaged trust. Perhaps this should not surprise us: increasing individual autonomy may increase the autonomy of those in positions of power, so adding to their opportunities for untrustworthy action and to others’ reasons for mistrusting them. Perhaps reducing the autonomy of any agents and institutions who might act in untrustworthy ways would help to restore trust. Is some loss of trustworthiness and of trust an acceptable price for achieving greater respect for autonomy? Do we have to choose between respect for individual autonomy and relations of trust? None of these prospects would be particularly welcome: we prize both autonomy and trust. Yet can we have both?

#### Turns the aff—trust key to agency and better health outcomes.

Susan Dorr Goold 99, MD, MHSA, MA, "The Doctor–Patient Relationship," J Gen Intern Med. Jan 1999; 14(Suppl 1): S26–S33, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1496871/>, DOA: 1-24-15, y2k

The doctor–patient relationship has been and remains a keystone of care: the medium in which data are gathered, diagnoses and plans are made, compliance is accomplished, and healing, patient activation, and support are provided.1 To managed care organizations, its importance rests also on market savvy: satisfaction with the doctor–patient relationship is a critical factor in people's decisions to join and stay with a specific organization.2–5 The rapid penetration of managed care into the health care market raises concern for many patients, practitioners, and scholars about the effects that different financial and organizational features might have on the doctor–patient relationship.6–10 Some such concerns represent a blatant backlash on the part of providers against the perceived or feared deleterious effects of the corporatization of health care practices. But objective and theoretical bases for genuine concern remain. This article examines the foundations and features of the doctor–patient relationship, and how it may be affected by managed care. Go to: A SPECIAL RELATIONSHIP The relationship between doctors and their patients has received philosophical, sociological, and literary attention since Hippocrates, and is the subject of some 8,000 articles, monographs, chapters, and books in the modern medical literature. A robust science of the doctor–patient encounter and relationship can guide decision making in health care plans. We know much about the average doctor's skills and knowledge in this area, and how to teach doctors to relate more effectively and efficiently.11, 12 We will first review data about the importance of the doctor–patient relationship and the medical encounter, then discuss moral features. We describe problems that exist and are said to exist, we promulgate principles for safeguarding what is good and improving that which requires remediation, and we finish with a brief discussion of practical ways that the doctor–patient relationship can be enhanced in managed care. The medical interview is the major medium of health care. Most of the medical encounter is spent in discussion between practitioner and patient. The interview has three functions and 14 structural elements (Table 1).13 The three functions are gathering information, developing and maintaining a therapeutic relationship, and communicating information.14 These three functions inextricably interact. For example, a patient who does not trust or like the practitioner will not disclose complete information efficiently. A patient who is anxious will not comprehend information clearly. The relationship therefore directly determines the quality and completeness of information elicited and understood. It is the major influence on practitioner and patient satisfaction and thereby contributes to practice maintenance and prevention of practitioner burnout and turnover, and is the major determinant of compliance.15 Increasing data suggest that patients activated in the medical encounter to ask questions and to participate in their care do better biologically, in quality of life, and have higher satisfaction.16 Functions and Elements of the Medical Interview Effective use of the structural elements of the interview also affect the therapeutic relationship and important outcomes such as biological and psychosocial quality of life, compliance, and satisfaction. Effective use gives patients a sense that they have been heard and allowed to express their major concerns,17 as well as respect,18 caring,19 empathy, self-disclosure, positive regard, congruence, and understanding,20 and allows patients to express and reflect their feelings21 and relate their stories in their own words.22 Interestingly, actual time spent together is less critical than the perception by patients that they are the focus of the time and that they are accurately heard. Other aspects important to the relationship include eliciting patients' own explanations of their illness,23, 24 giving patients information,25, 26 and involving patients in developing a treatment plan.27 (For an overview of this area of research, see Putnam and Lipkin, 1995.28) A series of organizational or system factors also affect the doctor–patient relationship. The accessibility of personnel, both administrative and clinical, and their courtesy level, provide a sense that patients are important and respected, as do reasonable waiting times and attention to personal comfort. The availability of covering nurses and doctors contributes to a sense of security. Reminders and user-friendly educational materials create an atmosphere of caring and concern. Organizations can promote a patient-centered culture,29 or one that is profit- or physician-centered, with consequences for individual doctor–patient relationships. Organizations (as well as whole health care systems) can promote continuity in clinical relationships, which in turn affects the strength of in those relationships. For instance, a market-based system with health insurance linked to employers' whims, with competitive provider networks and frequent mergers and acquisitions, thwarts long-term relationships. A health plan that includes the spectrum of outpatient and inpatient, acute and chronic services has an opportunity to promote continuity across care settings. The competition to enroll patients is often characterized by a combination of exaggerated promises and efforts to deliver less. Patients may arrive at the doctor's office expecting all their needs to be met in the way they themselves expect and define. They discover instead that the employer's negotiator defines their needs and the managed care company has communicated them in very fine or incomprehensible print. Primary care doctors thus become the bearers of the bad news, and are seen as closing gates to the patient's wishes and needs. When this happens, an immediate and enduring barrier to a trust-based patient-doctor relationship is created. The doctor–patient relationship is critical for vulnerable patients as they experience a heightened reliance on the physician's competence, skills, and good will. The relationship need not involve a difference in power but usually does,30 especially to the degree the patient is vulnerable or the physician is autocratic. United States law considers the relationship fiduciary; i.e., physicians are expected and required to act in their patient's interests, even when those interests may conflict with their own.9 In addition, the doctor–patient relationship is remarkable for its centrality during life-altering and meaningful times in persons' lives, times of birth, death, severe illness, and healing. Thus, providing health care, and being a doctor, is a moral enterprise. An incompetent doctor is judged not merely to be a poor businessperson, but also morally blameworthy, as having not lived up to the expectations of patients, and having violated the trust that is an essential and moral feature of the doctor–patient relationship.31 Trust is a fragile state. Deception or other, even minor, betrayals are given weight disproportional to their occurrence, probably because of the vulnerability of the trusting party (R.L. Jackson,

### 1NC—Bioterror !

**Key to solve bioterror- research, response and treatment --- it’s high now**

**Jacobs, 5** – MD; Boston University professor of medicine

[Alice, director of Cardiac Catheterization Laboratory and Interventional Cardiology, "Rebuilding an Enduring Trust in Medicine," Circulation, 2005, circ.ahajournals.org/content/111/25/3494.full#xref-ref-3-1, accessed 8-18-14]

To be sure, we will learn about the emerging science and clinical practice of cardiovascular disease over the next four days. But **there is an internal disease** of the heart **that confronts** us as **scientists**, as **physicians**, **and** as **healthcare professionals**. It is a threat to us all—insidious and pervasive—and one that we unknowingly may spread. **This threat is one of the most critical issues facing our profession** today. How we address this problem will shape the future of medical care.¶ **This issue is** **the** **erosion of trust.**¶ **Lack of trust is a barrier between our intellectual renewal and our ability to deliver** this new **knowledge to our research labs**, to our **offices**, to the bedside of our **patients, and** to **the public.** **Trust is** a **vital**, unseen, and essential **element in diagnosis, treatment, and healing**. So it is fundamental that we understand what it is, why it’s important in medicine, its recent decline, and what we can all do to rebuild trust in our profession. Trust is intrinsic to the relationship between citizens around the world and the institutions that serve their needs: government, education, business, religion, and, most certainly, medicine.¶ Albert Einstein recognized the importance of trust when he said, “Every kind of peaceful cooperation among men is primarily based on mutual trust.”1 In our time, trust has been broken, abused, misplaced, and violated. The media have been replete with commentaries, citing stories of negligence, corruption, and betrayal by individuals and groups in the public and private sectors, from governments to corporations, from educational institutions to the Olympic Organizing Committee. These all are front-page news. Perhaps the most extreme example is terrorism, in which strangers use acts of violence to shatter trust and splinter society in an ongoing assault on our shared reverence for human life.¶ Unfortunately, we are not immune in our own sphere of cardiovascular medicine. The physician-investigator conflicts of interest concerning enrollment of patients in clinical trials, the focus on medical and nursing errors, the high-profile medical malpractice cases, the mandate to control the cost of health care in ways that may not be aligned with the best interest of the patient—all of these undermine trust in our profession. At this time, when more and more public and private institutions have fallen in public esteem, restoring trust in the healthcare professions will require that we understand the importance of trust and the implications of its absence.¶ Trust is intuitive confidence and a sense of comfort that comes from the belief that we can rely on an individual or organization to perform competently, responsibly, and in a manner considerate of our interests.2 It is dynamic, it is fragile, and it is vulnerable. Trust can be damaged, but it can be repaired and restored. It is praised where it is evident and acknowledged in every profession. Yet it is very difficult to define and quantify.¶ Trust is easier to understand than to measure. For us, trust may be particularly difficult to embrace because it is not a science. Few instruments have been designed to allow us to evaluate it with any scientific rigor. Yet, **trust is inherent to our profession**, **precisely** because patients **turn to us in their most vulnerable moments, for knowledge about their** health and **disease**. **We know trust when** we experience it: when **we advise patients in need of highly technical procedures** that are **associated with increased risk** or when we return from being away to learn that our patient who became ill waited for us to make a decision and to discuss their concerns, despite being surrounded by competent colleagues acting on our behalf.¶ Many thought **leaders in the medical field understand the importance of trust**.3 **When asked whether the public health system could be overrun by public panic over** SARS and **bioterror**ism, **C**enters for **D**isease **C**ontrol and Prevention **Director** Julie **Gerberding replied, “You can manage people if they trust you. We’ve put a great deal of effort into** improving state and local communications and scaled up our own public affairs capacity…we’re **building credibility**, **competence and trust**.”4¶ Former **H**ealth and **H**uman **S**ervices **Secretary** Donna **Shalala** also **recognized the importance of trust when she said, “If we are to keep testing new med**icine**s and new approaches to curing disease, we cannot compromise the trust and willingness of patients to participate in clinical trials.**”5¶ These seemingly intuitive concepts of the importance of trust in 21st century medicine actually have little foundation in our medical heritage. In fact, a review of the early history of medicine is astonishingly devoid of medical ethics. Even the Codes and Principles of Ethics of the American Medical Association, founded in 1847, required patients to place total trust in their physician’s judgment, to obey promptly, and to “entertain a just and enduring sense of value of the services rendered.”6 Such a bold assertion of the authority of the physician and the gratitude of the patient seems unimaginable today.¶ It was not until the early 1920s that role models such as Boston’s Richard Cabot linked patient-centered medical ethics with the best that scientific medicine had to offer,6 and Frances Weld Peabody, the first Director of the Thorndike Memorial Laboratory at the Boston City Hospital, crystallized the ethical obligation of the physician to his patient in his essay “The Care of the Patient.”7 In one particularly insightful passage, Peabody captures the essence of the two elements of the physician’s ethical obligation: He must know his professional business and he must trouble to know the patient well enough to draw conclusions, jointly with the patient, as to what actions are indeed in the patient’s best interest. He states: “The treatment of a disease may be entirely impersonal: **The care of the patient must be completely personal**. **The** significance of the intimate personal **relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it.”** Truly, as Peabody said, “The secret to the care of the patient…is in caring for the patient.”7¶ **This concept that links the quality of the physician-patient relationship to health outcomes has** indeed **stood the test of time**. **Trust has been shown to be important** in its own right. **It is essential to patients, in their willingness to seek care**, their **willingness to reveal sensitive info**rmation, **their willingness to submit to treatment, and their willingness to follow recommendations**. **They must be willing for us to be able.**

**Continual research solves and deters bioterror**

**Chyba 4** - Co-Director of the Center for International Security and Cooperation (CISAC), Stanford Institute for International Studies, and an Associate Professor at Stanford University [Christopher & Alex Greninger, “Biotechnology and Bioterrorism: An Unprecedented World” Survival, 46:2, Summer 2004, http://iis-db.stanford.edu/pubs/20722/Chyba\_2004.pdf]

In the absence of a comprehensive and effective system of global review of potential high-consequence research, we are instead trapped in a kind of offence–defence arms race. Even as legitimate **biomedical researchers develop** **defences against bio**logical **pathogens**, bad actors could in turn engineer countermeasures in a kind of directed version of the way natural pathogens evolve resistance to anti-microbial drugs. The mousepox case provides a harbinger of what is to come: just as the United States was stockpiling 300m doses of smallpox vaccine as a defence against a terrorist smallpox attack, experimental modification of the mousepox virus showed how the vaccine could possibly be circumvented. The United States is now funding research on antiviral drugs and other ways of combating smallpox that might be effective against the engineered organism. Yet there are indications that smallpox can be made resistant to one of the few known antiviral drugs. **The future has the appearance of an eternal arms race** of measures and countermeasures. The ‘arms race’ metaphor should be used with caution; it too is in danger of calling up misleading analogies to the nuclear arms race of the Cold War. First, **the biological arms race is an offence–defence race**, rather than a competition between offensive means. Under the BWC, only defensive research is legitimate. But more fundamentally, the driver of de facto offensive capabilities in this arms race is not primarily a particular adversary, but rather the ongoing global advance of microbiological and biomedical research. **Defensive measures are in a race with nefarious applications**of basic research, much of which is itself undertaken for protection against natural disease. In a sense, we are in an arms race with ourselves. It is hard to see how this arms race is stable – an offence granted comparable resources would seem to be necessarily favoured. As with ballistic missile defence, particular defensive measures may be defeated by offensive countermeasures. **In the biological case, implementing defensive measures will require** not only **research** but drug development and distribution plans. Offensive measures need not exercise this care, although fortunately they will likely face comparative resource constraints (especially if not associated with a state programme), and may find that some approaches (for example, to confer antibiotic resistance) have the simultaneous effect of inadvertently reducing a pathogen’s virulence. The defence must always guard against committing the fallacy of the last move, whereas the offence may embrace the view of the Irish Republican Army after it failed to assassinate the British cabinet in the 1984 Brighton bombing: ‘Today we were unlucky, but remember we have only to be lucky once – you will have to be lucky always’.40 At the very least, **the defence will have to be vigilant** and collectively smarter than the offence. **The only way for the defence to win** convincingly in the biological arms race **would** seem to **be to succeed in discovering and implementing** certain de facto **last-move defences**, at least on an organism-by-organism basis. Perhaps there are defences, or a web of defences, that will prove too difficult for any plausible non-state actor to engineer around. Whether **such defences** exist is unclear at this time, but their exploration **should be a long-term research goal of US biodefence** efforts. Progress might also have an important impact on international public health. One of the ‘Grand Challenges’ identified by the Bill and Melinda Gates Foundation in its $200m initiative to improve global health calls for the discovery of drugs that minimise the emergence of drug resistance – a kind of ‘last move’ defence against the evolutionary countermeasures of natural microbes.41 **Should** a collection of such **defensive moves prove possible, bioterror**ism **might** ultimately **succumb to** a kind of globalised **dissuasion by denial**:42 **non-state groups would calculate** that **they could not** hope to **achieve dramatic results through biological programmes** and would choose to direct their efforts elsewhere.

**Extinction- engineered pathogens**

**Sandberg, 8** -- Oxford University Future of Humanity Institute research fellow

[Anders, PhD in computation neuroscience, and Milan Cirkovic, senior research associate at the Astronomical Observatory of Belgrade, "How can we reduce the risk of human extinction?" Bulletin of the Atomic Scientists, 9-9-2008, thebulletin.org/how-can-we-reduce-risk-human-extinction, accessed 8-13-14]

The risks from anthropogenic hazards appear at present larger than those from natural ones. Although great progress has been made in reducing the number of nuclear weapons in the world, humanity is still threatened by the possibility of a global thermonuclear war and a resulting nuclear winter. We may face even greater risks from emerging technologies. **Advances in synthetic biology** might **make it possible to engineer pathogens capable of extinction-level pandemics**. **The knowledge, equipment, and materials needed to engineer pathogens are more accessible than those needed to build nuclear weapons.** And **unlike other weapons, pathogens are self-replicating, allowing a small arsenal to become exponentially destructive.** **Pathogens have been implicated in the extinctions of many** wild **species**. **Although most pandemics "fade out" by reducing the density of susceptible populations,** **pathogens with wide host ranges in multiple species can reach even isolated individuals.** The intentional or unintentional release of **engineered pathogens with high transmissibility, latency, and lethality might be capable of causing human extinction**. While such an event seems unlikely today, the likelihood may increase as biotechnologies continue to improve at a rate rivaling Moore's Law.

unpublished manuscript).

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### 2NR L—Bolster

#### Risk perception

O’Neill 1 (ONORA O’NEILL, philosopher and a crossbench member of the House of Lords, “AUTONOMY AND TRUST IN BIOETHICS”, 2001)//Miro

The targets of public mistrust have been widely discussed across the last thirty years both in sociological discussions of the ‘risk society’ and in the media. Leading sociologists have noted that many technical and social practices – prominently among them medicine, science and biotechnology – have become larger and more remote, and are seen as more laden with hidden risks, and that fears have multiplied with the globalisation of economic and technical processes. The fears and anxieties of ‘risk societies’ focus particularly on hazards introduced (or supposedly introduced) by high-tech medicine and genetic technologies, by nuclear installations and use of agrochemicals, by processed food and intrusive information technologies. Yet it is open to doubt whether most people in the richer parts of the world encounter risks that they can do less to control than earlier generations could do to control risks they faced. Traditional hazards such as endemic tuberculosis or contaminated water supplies, food scarcity and fuel poverty were neither minimal nor controllable by those at risk from them in the recent past, and are neither minimal nor controllable for those who still face them in poorer societiestoday. The claim that richer societies have become ‘risk societies’ is a claim not about levels of risk, but about changes in perceptions of risk, or at least in reported perceptions of risk. It is a claim about a supposedly widespread loss of confidence in the capacities of medical, scientific and technical progress to solve problems, and about a corresponding growth in reported anxiety and mistrust. These perceptions have currency among populations who in fact live longer and healthier lives than their predecessors enjoyed. Yet the claim about perceptions is accurate. In the UK, for example, MORI public opinion polls confirm that many members of the public now claim to distrust numerous groups and professionals to tell the truth about medical, scientific and environmental issues.

# Backend

## Links

### PAS

**Aff destroys doctor-patients relations**

**Foley & Hendin 2** Dr. Kathleen Foley chairs the International Association for Hospice and Palliative Care and is a member of the Institute of Medicine of the National Academies—AND—Dr. Herbert Hendin is Professor in the Department of Psychiatry and Behavioral Sciences at New York Medical College, “In The Case against Assisted Suicide: For the Right to End-of-Life Care,” EBSCO, DOA: 10-19-14, y2k

Actual abuses aside, **the legalized practice of physician-assisted death will almost certainly damage the doctor-patient relationship**. True, some may be relieved to know that their old family doctor will now provide suicide assistance when asked. But **many**—**especially those who have** **difficulty communicating** their **wishes** and defending their interests or who lack a close relationship with a trusted personal doctor—**will rightly** **be suspicious**. **For how can you trust stranger-doctors to be** wholeheartedly **devoted to your best interests once they have a license to kill?** Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital after a fall with fractured ribs, and you have pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. Never mind that, for now, death can be legally prescribed only on request. How soundly will you sleep? Trust will suffer profoundly in subtler ways as well. **Should** physician-**assisted** **death become a legal** and a medical **option**, **it will enter** unavoidably—sometimes explicitly, sometimes tacitly—**into many a doctor-patient encounter.** Though there may be attempts to prevent physicians from introducing the subject, once the choice for active killing exists as a legal right and medical option, there will be even stronger pressures to make sure that patients know they have the choice.12 Ineluctably, **patients will now be forced to wonder about their doctors, regardless of how they handle the situation: did the doctor introduce the subject because he secretly or unconsciously wishes to abandon me, or, worse, because he wishes I were dead? Does the doctor avoid the subject for the same reasons, fearing I will suspect the truth, or, conversely, is it because he is indifferent to my suffering**? Few patients will openly express such fears and doubts. Because patients must rely on their doctor, they do not want to risk alienating him by seeming to distrust his motives and goodwill. **Anyone** who understands even a little of the subtle psychodynamics of the doctor-patient relationship **can see** immediately **the corrosive effects** **of doubt and suspicion that will be caused by** explicit (or avoided) speech about **physician-assisted death**. Trust is no mere moral nicety, humanly desirable but medically dispensable. On the contrary, **a patient’s trust in the physician is a necessary ingredient in the therapeutic relationship and**, at least indirectly, in the **healing process** itself. **Mistrust produces stress, anger, and resistance to treatment**. In the increasingly impersonal world of modern medicine, patients must, without any direct evidence, presume that their caregivers are trustworthy even before they have shown that they deserve to be trusted. Especially under these conditions, the trust given to each physician stems largely from the trustworthiness attached to the profession as a whole. **With the taboo against physician-assisted killing broken, legitimate fears of deadly abuse of the new license will attach even to the most honorable physicians**, **whose ability to heal** and comfort **will** therefore often **be compromised**. It will not matter that your doctor has never yet put anyone to death; that the profession is legally entitled to do so will make a world of difference.

#### Legalizing PAS crushes trust and shatters the foundation of medicine

By Ryan T. Anderson 15, Ph.D., William E. Simon Fellow in Religion and a Free Society DeVos Center for Religion and Civil Society, editor of Public Discourse, the online journal of the Witherspoon Institute of Princeton, N.J., bachelor of arts degree from Princeton University, graduating Phi Beta Kappa and magna cum laude. He earned his doctoral degree in political philosophy from the University of Notre Dame, where he received his master’s degree. “Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality” Heritage, http://www.heritage.org/research/reports/2015/03/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak-corrupts-medicine-compromises-the-family-and-violates-human-dignity-and-equality

Corrupting the Practice of Medicine¶ Physician-assisted suicide threatens to:¶ Corrupt the culture in which medicine is practiced;¶ Corrupt the profession of medicine by permitting the tools of healing to be used as a technique for killing;¶ Fundamentally distort the doctor–patient relationship, greatly reducing patients’ trust of doctors and doctors’ undivided commitment to the healing of their patients; and¶ Create perverse incentives for insurance providers and the financing of health care.¶ Physician-Assisted Suicide Corrupts the Profession of Medicine. The heart of medicine is healing. Doctors cannot heal by assisting patients to kill themselves or by killing them. They rightly seek to eliminate disease and alleviate pain and suffering. They may not, however, seek to eliminate the patient. Allowing doctors to assist in killing threatens to fundamentally corrupt the defining goal of the profession of medicine.¶ In testimony before the U.S. House of Representatives, Dr. Kass elaborated on this point:¶ The legalization of physician-assisted suicide will pervert the medical profession by transforming the healer of human beings into a technical dispenser of death. For over two millennia the medical ethic, mindful that power to cure is also power to kill, has held as an inviolable rule, “Doctors must not kill.”[57]¶ Dr. Paul McHugh agrees that this inviolable rule is essential to the practice of medicine:¶ Since ancient Greece physicians have been tempted to help desperate patients kill themselves, and many of those Greek doctors must have done so. But even then the best rejected such actions as unworthy and, as the Hippocratic Oath insists, contrary to the physician’s purpose of “benefiting the sick.”[58]¶ For this reason, the American Medical Association (AMA) code of ethics rejects physician-assisted suicide. The AMA states: “Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer.”[59] As law professor O. Carter Snead notes,[60] dozens of professional associations and groups representing vulnerable persons oppose physician-assisted suicide, including the:¶ American Medical Association,¶ World Health Organization,¶ American Nurses Association,¶ American Association of Critical-Care Nurses,¶ Hospice Nurses Association,¶ Oncology Nurses Society,¶ American Osteopathic Association,¶ American Psychiatric Association,¶ American Academy of Hospice and Palliative Medicine,¶ American Academy of Pain Management,¶ American Academy of Pain Medicine,¶ American Academy of Orthopaedic Surgeons,¶ American Academy of Physical Medicine,¶ Society of Critical Care Medicine,¶ American Academy of Neurology,¶ American Neurological Association,¶ American Society of Anesthesiologists,¶ American Society of Clinical Pathologists,¶ College of American Pathologists,¶ American Society of Abdominal Surgeons,¶ American Association of Clinical Endocrinologists,¶ Society of Medical Consultants to the Armed Forces,¶ American Institute of Life Threatening Illness and Loss,¶ Massachusetts Medical Society,¶ Disability Rights Education and Defense Fund,¶ American Disabled for Attendant Programs Today,¶ American Association of People with Disabilities,¶ Association of Programs for Rural Independent Living,¶ Justice for All,¶ National Council on Disability,¶ National Council on Independent Living,¶ National Spinal Cord Injury Association,¶ Not Dead Yet,¶ TASH,¶ World Association of Persons with Disabilities, and¶ World Institute on Disability.¶ Practicing medicine is a not a morally neutral act of mere technical skill. Physicians do not practice medicine simply to fulfil the desires of consumer-patients, whatever those desires may be. Rather, medicine is a profession governed by its core commitment to healing patients. Dr. Kass explains that professionals profess their devotion to the purposes they serve and the ideals to which they look. Teachers are devoted to learning, lawyers to justice, clergy to things divine, and “the physician devotes himself to healing the sick, looking up to health and wholeness.” Dr. Kass adds: “Healing is thus the central core of medicine: to heal, to make whole, is the doctor’s primary business.”[61]¶ Killing is incompatible with caring. Dr. Kass explains: “Can wholeness and healing ever be compatible with intentionally killing the patient? Can one benefit the patient as a whole by making him dead?… ‘Better off dead’ is logical nonsense.” Indeed, “to bring nothingness is incompatible with serving wholeness: one cannot heal—or comfort—by making nil. The healer cannot annihilate if he is truly to heal. The boundary condition, ‘No deadly drugs,’ flows directly from the center, ‘Make whole.’”[62]

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